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ABSTRACT

Nonbehavioral models to child therapy that attempt to train parents as paraprofessionals primarily follow Rogerian or family systems approaches. Filial Therapy (Guerney, 1964) represents the most purely Rogerian mode and trains parents exclusively in Rogerian techniques in the context of play therapy. Other Rogerian models have been developed with procedural differences. Nickerson's (1973) use of art involves differences in therapeutic medium. Kraft's (1973) didactic approach alters both length of treatment and program structure. Ginott's (1961) group play therapy approach with children only indirectly includes the parents in a guidance group, while Ginsberg (1976) uses filial therapy in a group format. Both of these approaches employ differences in treatment context. There are four models which combine Rogerian and family systems approaches. Hornsby and Applebaum (1978) apply both approaches to treat parents and the child. Safer (1965) developed a conjoint play therapy approach with high therapist involvement in parent-child sessions. Resnick's (1976) approach focuses on meta-communication, and Gordon's (1970) Parent Effectiveness Training uses a didactic approach with the parents. These nine approaches can be evaluated by examining paraprofessional advantages, general therapy characteristics, population characteristics, contraindication for treatment, and research evidence of effectiveness. Although valid and reliable empirical evidence is scarce, it appears that all of the models are promising and may be quite effective if employed in specific circumstances with the most appropriate populations. The paper concludes with a three-page list of references. (NB)

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NON-BEHAVIORAL APPROACHES TO PARAPROFESSIONAL TRAINING FOR PARENTS

By

JOHN LAWRENCE STEWARD

CG 019363

A doctoral research paper submitted to
Rosemead School of Psychology
in partial fulfillment of the requirements
for the degree of
Doctor of Psychology

La Mirada, California

1986

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Doctoral Research Paper
for the Degree of Doctor of Psychology

ROSEMEAD SCHOOL OF PSYCHOLOGY

BIOLA UNIVERSITY

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Abstract

This paper analyzes nine models of nonbehavioral approaches to paraprofessional training for parents. Following a description of each approach, the models are evaluated based upon a) the claimed advantages of paraprofessional training for parents, b) the general therapy characteristics, c) the treatment population characteristics, d) the contraindications for treatment, and e) the evidence for therapeutic effectiveness. Conclusions address the model's most appropriate application given various treatment conditions.

Non-Behavioral Approaches to Paraprofessional Training for Parents

This paper focuses upon non-behavioral approaches to child therapy that attempts to train the parents as paraprofessionals. The modalities include only those major therapeutic approaches with both the parent and child or just the parent in treatment. This is in contrast to non-behavioral approaches conducting primarily individual child therapy. The crucial difference between child therapy with a parent and individual child therapy is the former focuses upon the parent-child relationship, where the latter focuses only on the child. The former also places greater emphasis on parent involvement in treatment. The proponents of the parent-child relationship modalities contend that this approach is beneficial therapeutically over individual child psychotherapy since it focuses upon the most important relationship in the child's life. Though this paper does not attempt to resolve the conflict as to which of these two major schools (parent-child therapy vs. individual child therapy) may be more effective, this paper evaluates the relative effectiveness of different parent-child relational models. The discussion includes nine parent-child theories.

The discussion of the various models includes a brief presentation of the conceptual and the technical features of each, followed by a presentation of the dimensions for evaluating the models, with a subsequent evaluation, and finally a summary and conclusion from this analysis. The discussion of the therapeutic models will begin with a general overview.

Therapy Approaches

The nine therapies are subsumed under three major orientations: Rogerian, Rogerian with procedural differences, and Rogerian and Family Systems. The Rogerian category is characterized by any approach that primarily uses Roger's techniques to understand and to facilitate the parent-child relationship. The model for addressing the parent-child relationship from a pure Rogerian position is developed by Guerney (1964), called Filial Therapy. The second category encompasses Rogerian oriented models which diverge from the basic Filial Therapy. The variations revolve around technique, play medium or length of treatment (Ginott, 1961; Ginsberg, 1976; Kraft, 1973; and Nickerson, 1973). The third category combining Rogerian and family systems orientation were developed by Safer (1965), Resnick (1976) and Gordon (1970). Each of these models will be described within their respective categories.

Rogerian Therapy

The predominant feature of Filial Therapy is the sole reliance upon Rogerian techniques to maximize the parent-child relationship through teaching parents the necessary skills. The parents meet on a weekly basis with the therapist to learn non-directive play therapy skills. The intentions of the play therapy are three-fold. First, allow corrections in the child's perception or misperception of the parent's feelings, attitudes, or behavior towards him. Second, facilitate the child's expression of hidden or repressed thoughts, of needs and of feelings to the parent during play. Third, facilitate the child's experiencing a greater feeling of self-respect, self-worth, and self-confidence. The psychologist instructs parents in client-centered techniques according to Carl Rogers. These are exemplified in the works of Moustakas (1953) and Dorfman (Rogers, 1951). The parents begin this training process in parent groups.

The parent training groups (with 6 to 8 adults) consists of mothers and fathers who are not spouses of each other, which provides greater group facilitation. Both spouses are strongly encouraged to attend, though they are placed in different treatment groups. Parents learn the techniques via demonstration play sessions conducted by the therapists and by role playing. To

further enhance the learning process, the therapist uses a client-centered approach to explore the parent's feelings and attitudes. The therapy consists of three general stages. Stage 1 consists of two parts. In the first part of stage 1 the psychologist explains the benefits for the child and for the parent-child relationship as a result of the play sessions. This is usually described in terms of the release from tension-producing inner conflict, the freer communication processes from child to parent, and the child's greater sense of self-direction, self-respect and self-confidence. As this occurs, the professional employs empathy skills to explore the parents' various feelings and reactions. In addition to discussing specific play therapy techniques, the goals of the sessions are explained to the parents.

Genuineness and empathy are emphasized for effective therapy as parents learn specific techniques. Traditional Rogerian techniques such as structuring, stating of content and clarifying feelings are taught to the parents. To promote learning, the therapist conducts several demonstration sessions with normal children, then conducts sessions with the parents' children, and finally with the group via a one-way mirror.

In the second part of stage 1, the parents employ newly learned skills in the clinic. The parents practice

their newly defined role with either another parent's child or their own child before applying these techniques at home. The therapists' sessions and parents' sessions are discussed by the group to facilitate understanding and mastery of this novel empathic role. These discussions are task-oriented to maximize motivation and minimize resistance. The therapist does not encourage or discourage the use of Rogerian techniques at home during the second part of stage 1. The entire stage 1 process usually encompasses about 6 to 8 sessions.

Stage 2 is marked by the parents conducting play sessions at home with their own children using standard play therapy equipment. The play therapy session usually is 30 minutes in length. The material from the home play therapy sessions is used for group discussion to focus upon the parents' own emotional reactions, the children's emotional reactions, the techniques, the methodology and the task-oriented issues.

Stage 3, the final phase of treatment, focuses upon possible termination. When the therapist perceives the parent's successful incorporation and application of the skills, the professional suggests discontinuing the training. The success and possible termination is discussed with the group which offers feedback and support to the

parent. When the group decreases to 3 or 4 people they may be merged with another similarly diminished group.

In summary, Filial Therapy allows an unlimited time period primarily for parents to become more aware of their child's emotions, and secondarily to become aware of their own feelings as relates to their children. This process occurs by training the parents through three gradual stages to employ Rogerian techniques.

Rogerian Therapy with Procedural Differences

The historical move toward paraprofessional training, such as Guerney's Filial Therapy approach, spawned other therapeutic models with slight variations. There are four such models with procedural differences in 1) the treatment context (Ginsberg, 1976; Ginott, 1961); 2) the therapeutic medium (Nickerson, 1973) and 3) the length of treatment and the degree of structure, Kraft, 1973).

There are two approaches that vary the treatment context (Ginott, 1961; Ginsberg, 1976). The first model to consider is group filial therapy, proposed by Ginsberg (1976). This approach is essentially the same as filial therapy. The minor differences include giving the parents a training manual; conducting therapy with the parents, the children and the group leaders together during the first half-hour session; and meeting for six months rather than for an indeterminate period. Group filial therapy

attempts to accelerate treatment through a group experience, a training manual and a brief treatment period. In summary, Ginsberg employs filial therapy techniques in a group format, even instructing the parents in techniques during the first session.

Ginott (1961) offers another variation in treatment context by the children participating in group child psychotherapy and the parents participating in a parent guidance group. The child treatment group and the parents group is based upon Rogerian principles. The children's group consists of 5 to 6 children who attend 90-minute sessions once per week for an indefinite period, while the parents group involves 10 to 12 mothers who attend 90-minute sessions once a week for a period of 15 weeks. The parents never directly participate in the children's therapy and the parent's involvement in the adult group is optional. Ginott separates the groups of mothers as to the children's age, delineating between preschool children, grade school children and adolescents. During the first meeting the mothers are asked to state their complaints about their children and to formulate a reason for the failure of their disciplinary measures. When the mothers eventually turn to the staff for immediate solutions to these long-standing problems, the therapist explains the client-centered approach to solving problems

through understanding and personal insight. The leader basically helps the parents to understand the normalcy of ambivalent feelings, the importance of accepting this ambivalence and the meaning of their children's symptoms. Though their parents' group ends after 15 weeks, the children may continue in treatment as long as necessary.

In summary, Ginott separates groups for children and for parents, allows the children to remain in treatment for an indeterminate period and conducts the parents' group for a limited period. The parent training is primarily achieved through the implicit modeling by the therapist and through the similarity between the group experiences for the children and the parents' group.

The next area of variation is the therapeutic medium. Nickerson (1973) utilizes art as the primary vehicle for expression and change. Though she presents the therapy as applicable to the classroom, parents may also utilize this approach with their own child at home. Nickerson encourages the child to see who he is and who he might become, emphasizing the process rather than the product of the art. The therapist introduces the artistic medium by giving the child permission to express himself or herself in nontraditional and imperfect ways through various techniques such as scribbling, dripping globs of paint onto wet paper and conjointly drawing a complete

picture with another person. Any type of art material may be used that is easy to control and does not require great expertise to achieve expressive results. The parent encourages the child to think about what the selected colors mean to him. In the process of therapy several other techniques may be employed such as practicing rhythmic lines, drawing an abstract self portrait, drawing a symbolic portrait of each person in therapy based upon what the child has seen and heard in the group process, making a joint drawing with one or two other people, working with clay, and making scrapbooks, art posters, collages, collections, etc., to express and describe the child's experienced feelings and themes. The parent role involves encouragement and acceptance where there is no right or wrong and there is an enjoyment in the child's self-exploration. This therapeutic modality may be used in either a group or an individual setting.

In summary, Nickerson uses art as the primary therapeutic medium. The therapeutic process is global in nature emphasizing self-exploration, self-awareness and self acceptance.

Kraft (1973) developed another approach to conduct play therapy by altering length of treatment and program structure. He utilizes Ginott's principles for conducting

play therapy with children, training each parent in 10 group meetings to conduct play therapy with their children or with others' children. He emphasizes the principles of permissiveness, acceptance, limits, sublimation and insight. Though the other principles are somewhat self-explanatory, the concepts of sublimation and of insight may require elucidation. Sublimation is a redirection of the child's behavior away from violating limits of the play therapy to expressing feelings with the play therapy toys. The use of insight entails a quick remark, dramatization or a question at the appropriate time to help the child toward self-understanding. Kraft moves rapidly from an introductory lecture to parental involvement in the play sessions and the play sessions occur at home without the therapist present. The first training session focuses on elements of play therapy rather than the appropriate verbal response during the play therapy. Verbal skills are addressed later when parents discuss them in the group meetings. In addition, he avoids focusing upon the mother's problems. If the parents feel a need for further training, Kraft may allow the parents to continue if the parent takes the initiative to request further assistance, but he discourages continuation of treatment beyond the 10 sessions.

In summary, Kraft uses an accelerated treatment program by emphasizing a didactic structure, and immediate home play sessions. There is a greater emphasis upon technique and less direct involvement with the process of therapeutic change. Though he allows further treatment, this appears to be discouraged.

Several other therapists have developed strategies for child psychotherapy that incorporate parents, but use another theoretical orientation in conjunction with Rogerian techniques.

Rogerian Therapy with Family Systems Components

There are four modalities using Rogerian and family systems oriented approaches (Gordon, 1970; Hornsby & Applebaum, 1978; Resnick, 1976; Safer, 1965).

Hornsby and Applebaum use family systems and play therapy to work with both parents and the child instead of just one parent. They evaluate parents and child individually to determine intrapsychic dynamics, and they evaluate the family unit to assess the intrafamilial relationships and the degree of parent-child conflict. The parent who experiences less pathological conflict with the child is designated as the "primary therapist." This parent immediately begins 30-minute play sessions in the clinic while the other parent and the professional observe through a one-way mirror. The therapist guides

the sessions by using a bug-in-the-ear device, allowing direct communication between therapist and parent. A video tape is also simultaneously employed at the discretion of the professional. Following the session the parents meet with the psychologist for 30 minutes in conjoint parental therapy. The topic of these discussions are similar to the group format in filial therapy, focusing upon the parents' and the child's feelings and conclusions. The emphasis then shifts towards primarily exploring the parent's own feelings and problems in relationship to the child, especially those that occur within the play session.

In summary Hornsby and Applebaum vary the procedure by addressing the marital dyad, by conducting therapy with one family rather than in a group setting, by placing somewhat more emphasis on the parent's emotions and by incorporating family systems to fully understand the multiple relationships affecting the parent-child relationship.

Similarly, conjoint play therapy developed by Safer (1965) focuses upon limiting mutually unrewarding conflictive patterns of interaction between the child and parent and upon supporting positive behavior patterns. It stresses the interpersonal sphere and the parental world in the treatment process. The therapist, the child

and the parent all participate in the play sessions. After one or two play therapy sessions the conflictive patterns become spontaneous and are readily apparent. The therapist interrupts the negative interpersonal cycle and points out to the parent how his behavior may influence the child and why the parent or child responds in certain patterns. The therapist suggests more positive expressions and models beneficial communication patterns. Generally the therapist establishes the rules for the session such as who will initiate a session and which topics will be discussed. This format may be altered according to the specific needs of the parent and the child. For example, if a parent is very emotionally distant or clearly rejecting, the therapy is directed to facilitate cooperative actions between the parent and the child. The therapist also discusses specific conflictive patterns occurring in the home. The psychologist may demonstrate positive alternatives, support sublimations, encourage more direct verbal expressions of feeling and be successful in handling conflictive play interaction. Safer strongly encourages the participation of both parents in treatment; however, this is not a requirement. If the child wishes to play alone, the parent and the therapist may use this additional time to discuss matters of interest to the parent.

To summarize, the therapist is very involved in the actual play therapy with the parents and child while focusing upon conflictive interactions and communication patterns. There is also a spontaneous flexibility to work with either the parent, the child or both during the conjoint play therapy.

Another variaton (Resnick, 1976) integrates play therapy and family therapy as a technique for addressing meta communication patterns. Meta communication is basically the communication about a communication whether expressed verbally or nonverbally. This approach uses toy blocks as the medium to address pathological communication patterns. The quality of communication patterns becomes evident as the participants attempt to build identical structures with the blocks. The blocks are identical in number and shape and are given to both parent and child. In the first phase the follower (for example, the child) attempts to duplicate the leader's (for example, the parent) block construction without being able to see the other's construction. The follower may ask the leader as many questions as needed regarding this construction to make an accurate duplicate. After each construction is completed there is a face to face interaction attempting to determine where and how the errors occurred in the structures. When this

understanding is completed, the positions are reversed. The follower becomes the initiator of a construction and the same procedures are followed as above. The more pathological the communication patterns between the two people, the wider the discrepancy in their constructions. In the second phase, the participants are instructed to attempt to explore the feelings they are sensing from the other person during the block playing. During the entire process the procedures are controlled and facilitated by the therapist. The patients are instructed to use the block playing technique at home also. When homework is given, the beginning of these sessions focus upon who is in the leader role, the nature and the severity of the errors, the feelings engendered by hearing changes in each other's vocal qualities and the nature of the face-to-face interaction following the completion of the construction.

In summary, this approach emphasizes meta communication and the use of blocks to understand pathological communication patterns that maintains pathological relationships. The therapist assists in elucidating and resolving the troubled communications.

Another method, employing Rogerian and family therapy principles is promoted by Gordon (1970) under the rubric, Parent Effectiveness Training (P.E.T.). According to

P.E.T. theory, interpersonal exchanges should be congruent and noncoercive. Congruence refers to accepting one's own feelings and communicating them directly. Coercive relating occurs when a conflict results with one person winning and the other person losing. He hypothesizes most families are either authoritarian, wherein parents win, or they are permissive, wherein children win. P.E.T. advocates non-coercive, "no-lose" conflict resolution, whereby everyone's needs are taken into account and everyone participates in the final decision. Presumably, everyone wins. To facilitate congruent and non-coercive problem solving, P.E.T. trainers teach three sets of skills: counseling skills, confrontation skills, and problem-solving skills. The primary counseling skills are active listening, the primary confrontation skills are I-messages, and the problem-solving skills follow John Dewey's steps in rational problem solving: 1) identifying and defining the conflict, 2) generating possible alternative solutions, 3) evaluating the alternative solutions, 4) deciding on the best acceptable solution, 5) working out ways of implementing the solution, and 6) following up to evaluate the effectiveness of the solution. The basic program consists of eight weekly 3-hour classes consisting of 10 to 25 parents. After instructing and role play, the parents attempt to

apply these at home with their children. Parents are allowed to retake the classes if necessary.

To summarize, P.E.T. assumes coercive and non-congruent interpersonal interactions cause pathological relationships. The model seeks to resolve this by teaching counseling skills, confrontation skills and problem-solving skills. This concludes the presentation and description of the models.

To summarize the various models, there are two primary therapeutic approaches, Rogerian and Family Systems. These models are categorized into Rogerian proper, Rogerian with procedural differences and Rogerian with Family Systems. The pure Rogerian model, developed by Guerney (1964), attempts to train parents exclusively in Rogerian techniques in the context of play therapy. The Rogerian with procedural differences category includes several models. Nickerson (1973) uses art with a more directive approach than is typical of Rogerian intervention. Kraft (1973) teaches Rogerian techniques in a lecture format without attempting to directly oversee or become involved in the parent-child therapy. Ginott (1961) employs a group play therapy approach with children and only indirectly includes the parents in a guidance group that is peripheral to the child's treatment. Ginsberg (1976) essentially uses filial therapy in a

group format, completing treatment in six months. The Rogerian with family systems category has four models. Hornsby and Applebaum (1978) apply both Rogerian and family systems theory to treat parents and the child within a closely supervised program. Safer (1965) developed a conjoint play therapy approach with a high degree of therapist involvement in the parent-child session. Resnick (1976) focuses upon meta-communication of the parent and the child to resolve pathological patterns. Gordon (1970) uses a didactic approach with the parents, teaching skills to facilitate congruent, non-coercive interaction. Though the focus of treatment with these models is the parent-child relationship, each approach is quite different in what it brings to the therapeutic setting. Some evaluative criteria is necessary to analyze the relative benefit of each model.

Evaluation Criteria

The different therapeutic models will be evaluated along the five categories composed of a total of 19 dimensions. The first category is paraprofessional advantages, composed of the following aspects: a) the parents' involvement is a potent proof of parents' care for child, b) the parents' and child's self-awareness is increased, c) the therapist-parent relationship is facilitated, d) the probability for mental illness is

prevented, e) the chance for ameliorating the source of the parent-child conflict is increased, f) the potential for disrupting the marital or family members is decreased, and g) the working through of other problematic issues is increased (Ginsberg et al., 1978; Guerney, 1969; Ohlson, 1974; Safer, 1965; and Schwarz, 1950). The second category, general therapy characteristics, is composed of a) individual and/or group treatment, b) theoretical orientation, c) length of treatment for parent and for child, d) primary medium of therapy for parent and for child, e) therapeutic context, and f) therapist role. Types of therapeutic context include a) cotherapy with parent and child in the same treatment, b) parent and child together in treatment, c) collateral treatment, d) only parent in treatment, and e) only child in treatment. Type of therapist role includes a) nondirective, b) cotherapy with parent, c) semi-directive, and d) didactic. The third broad category, population characteristics, is composed of a) age, b) sex, c) socioeconomic status and d) diagnosis. The fourth category is contraindication for treatment. The fifth and final category is research evidence of effectiveness composed of a) empirical studies and b) case studies.

The criteria for determining if a model fulfills a dimension's description or even addresses the issue are

based upon several different types of evidence. The criteria range from this writer's impression, to the researchers' or clinicians' claims, including those by originators of the models, to case studies and ultimately to the empirical research. Determining whether a model fulfills the categories of evaluative criteria, is based upon this author's impression unless otherwise designated. Most of the decisions are based upon this writer's subjective evaluation rather than upon more objective empirical data. The reason for the minimal amounts of research to support these approaches to parent-child therapy seems unclear at this time, except for possibly the difficulty of developing accurate appropriate measurement instruments and of developing an efficient design to control extraneous confounding variables. Even with these limitations, a thoughtful and provocative evaluation of the various models will assist the clinician in placing the techniques in some perspective based upon the client's needs and his professional judgement. For example, if time is an important constraining factor, Kraft's (1973) approach, which is short-term and didactic, may be more practical and appropriate than Guerney's (1964) approach, which may last up to one year or more to achieve successful treatment outcome. If a group approach is preferred instead of an individual approach, Ginsberg's

(1976) model may be more helpful than those developed by Guerney (1964) or Hornsby et al (1978).

Table 1 will assist in organizing the dimensions and studies in relation to one another.

The table indicates which therapeutic model fulfills the characteristic advantages of a paraprofessional approach to parent-child therapy. Second, the table displays each model's general therapeutic characteristics, the therapeutic context for treatment, the therapist's role, the population characteristics, the contraindications for treatment and the type of evidence supporting the effectiveness of the therapy. In the next section, the models are discussed along the major dimensions described above.

Evaluation of Models

The first model, Guerney's (1964) Filial Therapy, is likely the most well developed of the therapeutic approaches. Filial Therapy fulfills all the advantages of parent-paraprofessional training. Parents' involvement is a potent proof of caring for the child since the child is well aware of the time and the emotional energy the parent is giving to the treatment. Also, as the parents acquire better listening skills the child will most probably sense this change. Increased self awareness of parent and child occurs through greater self exploration

Table 1

Therapy Models and Evaluative Categories[a]

Evaluative Categories	Orientation								
	Rogerian	Rogerian with Procedural Differences				Rogerian and Family Therapy			
	Guerney	Nickerson	Kraft	Ginott	Ginsberg	Hornsby & Appl baum	Safer	Resnick	Gordon
Advantages of Paraprofessional Training									
Parents involvement potent proof of care for child	Y	Y	P	Y	Y	Y	Y	Y	P
Increase self-awareness of parent and child	Y	Y	P	Y	Y	Y	Y	Y	P
Greater facilitation of positive therapist-parent relationship	Y	Y	P	P	Y	Y	Y	Y	N
Preventative of mental illness	P	Y	Y	Y	P	P	P	Y	N
Correct source of parent-child conflict	P	Y	P	P	Y	Y	P	Y	N
Decreased disruption to marital or family members	Y	P	P	P	P	Y	Y	Y	N
May facilitate working through other problematic issues	Y	Y	P	Y	Y	Y	Y	Y	N

[a]The following symbols are used in the table: N = No, does not satisfy this advantage. P = Partly satisfies this advantage. Y = satisfies this advantage.

Table 1 - Page 2

Therapy Models and Evaluative Categories[b]

Evaluative Categories	Orientation								
	Rogerian	Rogerian with Procedural Differences				Rogerian and Family Therapy			
	Guerney	Nickerson	Kraft	Ginott	Ginsberg	Hornsby & Appleboum	Safer	Resnick	Gordon
General Therapeutic Characteristics									
Individual/Group	I/G	I/G	I/G	G	G	I	I	I	G
Theoretical Orientation	R	RP	RP	PP	RP	RF	RF	RF	RF
Treatment Length									
For parent	6 m-1 y	U	10 se	15 se	6 m	U	U	U	8 se
For child	6 m-1 y	U	10 se	U	6 m	U	U	U	N/A
Medium of Therapy									
For parent	D/Pl	Art	D	D	D/Pl	D/Pl	D/Pl	BIPl	D
For child	Pl	Art	Pl	Pl	Pl	Pl	Pl	BIPl	N/A
Therapeutic Context									
Co-therapy with parent							X		
Parent and child together	X				X	X		X	
Collateral therapy				X					
Parent(s) only in therapy	X	X	X			X			X
Child only in therapy									
Therapist's Role									
Nondirective				X					
Co-therapist							X		
Semidirective	X						X	X	
Didactic		X	X		X				X

[b]The following symbols are used in the table: BIPl = Block Play Therapy. D = Discussion. G = Group therapy. I = Individual therapy. m = months. N/A = Not apply. Pl = Play Therapy. R = Rogerian therapy. RF = Rogerian and Family Systems therapy. RP = Rogerian therapy with procedural differences. se = therapy sessions. U = Unspecified. X = Applies to this approach. y = year.

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Table 1 - Page 3

Therapy Models and Evaluative Categories[c]

Evaluative Categories	Orientation								
	Rogerian	Rogerian with Procedural Differences				Rogerian and Family Therapy			
	Guerney	Nickerson	Kraft	Ginott	Ginsberg	Hornsby & Applebaum	Safer	Resnick	Gordon
Population Characteristics									
Age of child	2-10	U	4-8	3-13	2-10	U	4-7	U	U
Sex of child	M/F	U	M/F	U	M/F	U	U	U	U
Socioeconomic status	L-M	U	U	U	L-M	U	U	U	U
Diagnosis of child	S	U	U	S	S	S	U	U	U
Contraindication to Treatment	S	U	U	S	S	S	U	U	U
Research Evidence									
Empirical	X	No							X
Case study	X	No	X	X	X	X	X	X	

[c]The following symbols are used in the table: L-M = Low to Middle socioeconomic status. N = No research. S = Specified, see text. U = Unspecified. X = applies to this approach.

for the child in therapy and for the parent in a parenting group. Filial Therapy also facilitates a positive therapist-parent relationship since the parents are actively involved in the treatment process with the child and are the primary therapists' for the child. This treatment approach also offers prevention of mental illness, since the acquired skills may be easily transferred to the home when the parents and the child have remained in treatment for a suitable period of time. There may be a correction in the source of the parent-child conflict as a result of the length of treatment and the personalized treatment and the personalized attention from the therapist training the parents. However, if only one parent participates in treatment there is less of a chance to prevent mental illness and correct the source of the parent-child conflict. The other parent has a very significant impact on the other parent-child relationship. If one parent is not in treatment it is an important and significant loss to treatment. This treatment approach is likely not to disturb the marital or family relationships if both parents attend each treatment session. This allows for parallel growth by both spouses. Due to the length of treatment and the extensive training other problematic issues may also be worked through in the course of addressing the presenting complaint.

Concerning general therapeutic characteristics, in filial therapy the therapist focuses upon the individual parent's and the individual child's feelings within the parent-child relationship, so the approach may be considered "individual." The theoretical orientation is Rogerian and the length of treatment may extend from several months to more than a year depending upon individual needs and the parent's skill acquisition. Play is the primary medium for filial therapy. The therapeutic context takes place on several levels. Initially, the parent-child play sessions occur in the therapist's presence. Later, the parent holds therapy sessions with the child at home and then in the same week the parent will meet with the therapist in a parents group. The therapist role is semidirective, in that he or she allows the parents to initiate the important topics in a group training. However, therapists may also be didactic in that they focus upon skills that the parents need to learn as adequate paraprofessionals.

Concerning population characteristics, Guerney (1964) claims filial therapy is effective with children from 2 to 10 years old. He feels filial therapy is inappropriate for the following child diagnostic categories: psychosis, mental retardation, suicide, homicide, crisis intervention, and situational or routine developmental problems. He

does not address race, socioeconomic status or the parents' diagnosis in his claims. Empirical evidence indicates filial therapy is effective with children between the ages of 3 and 10 years old (Brown, 1979; Ginsberg, 1976; L. Guerney, 1979; Sensue, 1981, Stover & Guerney, 1967; Sywulak, 1977; and Wall, 1979). Filial therapy has been found effective with low socioeconomic families (Brown, 1979; Ginsberg, 1976) and with middleclass families (Guerney, 1966; Sensue, 1981; Stover & Guerney, 1967; Sywulak, 1977).

As regards contraindications for therapy, Guerney (1964) considers the following conditions or diagnosis as inappropriate for filial therapy: autistic children, schizophrenics who are out of contact with reality, crisis intervention, and situational or routine developmental problems. There has not been any research to support or refute these contraindications.

There are six studies that have empirically evaluated Guerney's (1964) claims about filial therapy's effectiveness. Stover and Guerney (1967) codes play sessions for parent's reflective and directive behavior and for children's statements indicating leadership, dependency, negative feelings and active aggression. They found an increase in nonverbal aggression and in negative verbal feeling statements as the parents were more reflective. Wall (1979)

found children increased their expression of negative feelings as indicated by the Burkes Behavior Rating Scale and the Family Relationship Test. The increase in nonverbal aggression and in negative feeling statements are assumed to be associated with therapeutic progress and the beginning of emotional health. Horner (1974) and Oxman (1971) employed filial therapy for children with problem behaviors. Both Horner and Oxman found a decrease in problem behaviors by using a problem checklist filled out by parents. Sywulak (1977) found an increase in parental acceptance and in child adjustment as measured by the Porter's Parental Acceptance Scale, the Filial Problem List and the Parent Checklist. These measures are completed by the parents. Sensue (1981) performed a follow-up of Sywulak's (1977) research. When using the same measures, the parents' degree of acceptance and the child's adjustment maintained significant improvement at 6 months and at 3 years after initial treatment. Ginsberg's (1976) research indicated a significant change in children's behavior when using Parental Report, school progress and sibling/peer interaction as empirical measures. The sibling/peer interaction is measured by parental and teacher reports, respectively. The children's behavior improved at home, at school and with sibling and peers. In addition to objective studies, researchers have drawn

upon case studies to investigate the efficacy of filial therapy.

There are two published case studies using filial therapy (L. Guerney, 1979; Guerney, 1966). L. Guerney (1979) found filial therapy to be effective with disabled, hyperactive, physical handicapped, and mildly retarded children based upon observing positive affective movement. The researcher also observed a movement from negative feelings toward the self and the other to positive feelings, from dependence towards independence, and from impaired impulse control to acquisition of greater self-regulation. Guerney (1966) reports using filial therapy with a 7-year-old manifesting headaches, poor eating, enuresis, nightmares, excessive masturbation, nailbiting, tic-like throat clearing, socially isolated, easily offended, fearing a physical aggression and flight from peer play. The therapist noted all symptoms were alleviated or greatly reduced by session 55. These case studies offer important information for continued research to further explore the nature and the reliability of filial therapy's curative effects.

In conclusion, filial therapy studies include empirical and case study research. The results are impressive at first glance, indicating that filial therapy is effective for a wide range of children with numerous presenting

problems. Although the evidence is favorable, the results are inconclusive due to the lack of reliability and validity research supporting measurement devices such as Porter's Parental Acceptance Scale, Burkes Behavior Rating Scale, Filial Problem List, Problem Checklist and Parent Rating Scale. There are two exceptions to this, the Family Relations Test and the FIRO-B Test, which have greater reliability and validity. Even with the current state of filial therapy research, this treatment modality may be effective in ameliorating parent-child relationship problems.

There are four studies (Ginott, 1961; Ginsberg, 1976; Kraft, 1973; and Nickerson, 1973) which employ different procedures than filial therapy within a Rogerian theoretical framework. Each is relatively distinctive and varies along the evaluative dimensions. Nickerson's (1973) use of art as a play therapeutic medium with the parent's involvement provides potent proof for the parent's care for the child since the parent and child are involved in treatment together. This approach also yields an increased self awareness by the parent and the child through their discussing the feelings and meanings behind the artistic expression. Nickerson provides little discussion as to the effects of this approach upon the therapist-parent relationship. However, one may surmise that the

therapist-parent relationship would be enhanced as the therapist directs and fosters the parent-child interaction through the art. The parent will likely feel gratitude as he or she becomes aware of the positive change in the parent-child relationship. As the therapist is aware of specific problems and conflicts, he or she may address these through the art medium. This can lead to prevention of mental illness and correct the source of the parent-child conflict. At the same time, the lack of structure provides an opportunity to work through problematic issues other than the presenting complaint. This therapeutic approach appears beneficial, as it fulfills several of the advantages of a paraprofessional training model.

General therapeutic characteristics include the use of art as the medium within the Rogerian theoretical approach which may be used with individuals or with groups. The treatment length is unspecified by Nickerson and may be presumed to be open ended and based upon the needs of the parent-child clients. The therapeutic context involves the therapist taking the role of a didactic trainer for the parent so that he or she may more effectively relate to and foster the child's development.

Nickerson does not provide specific guidelines as to the treatment population's characteristics. Further, she

does not designate contraindications in using this approach with children or parents. Nickerson's use of art as a play therapeutic medium bases the approach upon Ericksonian and Rogerian theory, but has yielded no empirical or case study evaluations to date.

To conclude, the model appears therapeutically useful, with the emphasis upon self-exploration, self-awareness and self acceptance. However, the model lacks fundamental evidence to support its efficacy.

Kraft's (1973) model only partially satisfies the major advantages for paraprofessional training. This is due primarily to the short-term nature of the treatment; he only provides 10 sessions. Though parent involvement in the therapeutic training is a potent proof of care for the child, the brevity of this training makes it difficult to imagine that lifelong patterns of interacting would be changed in a short period of time. It is doubtful that mere skill training without addressing some of the underlying emotional dynamics could produce healthy relationships. For example, new skills may just allow parents to more effectively use and manipulate their children. Increased self awareness may be minimal and limited to a few sessions, since training is only 10 sessions in length. This approach may facilitate a positive therapist-parent relationship since the training

is primarily created for them as recipients. However, there may be increased parental frustration due to the length of treatment. It may be difficult for some parents to adequately acquire the skills in such a short period of time. This approach may prevent further mental illness because some parents may acquire basic skills for exploring and understanding themselves and their children. However, families with greater pathology may not profit from this brief experience due to requiring more individual attention to cope with how their emotional problems may interfere with learning and subsequent application. The parent-child source of conflict may be corrected for those parents and children who are able to rapidly explore and address the problems. Yet, for less adept parent-child pairs the conflict source may require more lengthy treatment. Skill acquisition without adequate remediation of underlying pathology may exacerbate the problems, creating more entrenched and sophisticated pathological parenting. Lastly, Kraft's approach may not always facilitate the working through of other problematic issues. The brevity of treatment may only succeed in surfacing other problem areas without allowing adequate time to process the emotions related to those conflicts.

General therapeutic characteristics include a Rogerian approach with treatment lasting 10 sessions, using individual and group structure. The individual therapy occurs with a parent and a child in their home, but only the parents meet in a group with the therapist. The primary child medium is play and the parent's therapeutic medium is discussion. The therapist role in the parent meetings is primarily didactic.

Kraft claims the appropriate treatment population includes male and female children from 4 to 8 years old. He does not mention socioeconomic status or diagnosis in considering whether a child or a parent is appropriate for treatment. However in case study material he claims that this approach is effective for conflict resolution and for children who experience stuttering, passivity and organicity.

Kraft does not address contraindications for treatment. However, due to its brevity one may surmise that it is more effective and appropriate with higher functioning adults and children rather than in the lower functioning clients.

Kraft does not offer strong empirical research to support his theory of treatment. He presents five case studies focusing upon stuttering, passivity and organicity. According to his presentation, these treatments terminated

successfully. However, he does not give a rationale for why these diagnoses are especially amenable to his approach.

In conclusion, Kraft's model possesses excellent content and only seems to suffer from its short term approach which may restrict those who may benefit from this treatment. However, such an approach may provide an opportunity for parents who are limited to short-term treatment and who feel more comfortable with a didactic approach.

Ginott (1961) employs an approach that is similar to Kraft's (1973), using a short term treatment model for parent groups. The approach fulfills several major advantages of paraprofessional training because the children are in long term treatment and the parents have the opportunity to be involved in a parents' group. The long term treatment allows for sufficient time to address underlying emotional issues when in the hands of a competent therapist. If the child is aware of the parents' involvement in this treatment, this provides potent proof of care for the child. This dual treatment also affords an opportunity for increased self awareness of both the parent and the child since Ginott uses techniques to foster self exploration. However, the emphasis on awareness tends to be more intrapsychic than interpersonal

since the parent and child are in separate treatment groups. The chance for parents to be involved in a group experience facilitates the positive therapist-parent relationship. The long term nature of treatment may facilitate the child's working through the source of the parent-child conflict and many problematic issues other than just the presenting complaint. However, treating the parent only in short term group therapy limits the amount of help he or she may receive in resolving the relational conflict with the child. The child is more likely to resolve his or her conflicts and problems, while the parent may unwittingly continue encouraging pathology.

A group Rogerian approach is one of the general therapy characteristics of Ginott's model. The length of treatment for the children's group is unspecified, and for the parents' group is limited to 15 sessions. The primary medium for children is play and for parents is discussion. Usually only the child is in treatment unless the parents request additional assistance, in which case Ginott employs collateral treatment. The psychologist's role remains unchanged as a Rogerian therapist for both the children and the parents.

Ginott claims the potential treatment population for the children's group psychotherapy includes those

from age 3 to 13. He does not address the sex or the socioeconomic status of the clients as considerations for treatment. He postulates that this treatment is effective with children who are withdrawn, immature, phobic, effeminate, compulsive, precocious, conduct disordered and with some children who suffer from allergies and from reading disabilities.

Contraindications for inclusion in play therapy groups include children with intense sibling rivalries, sociopathy, accelerated sexual drives, past exposure to perverse sexual experiences, persistent stealing, aggressive behavior and gross stress reactions.

Concerning empirical evidence, Ginott cites case studies throughout the presentation of his group psychotherapy with children model. Even though these studies amplify the therapeutic principles and appear to validate the approach, they suffer from offering inconclusive evidence supporting its effectiveness.

In summary, Ginott offers a well respected model for treating parent-child relationships. He addresses important diagnostic characteristics and fulfills several advantages of a paraprofessional model. However, the lack of empirical support and the limited parental training may hinder the validity and the effectiveness of this model.

Ginsberg's (1976) group filial therapy is similar to Guerney's model and therefore has similar strengths. Since the parents are actively involved in treatment, this provides a potent proof for the child of his or her parents' care. The group structure or play therapy may possibly even further increase self awareness of the parent and the child because of the mutually stimulating effects of the mother-child pairs upon one another. In addition, the group format may help to diffuse conflicts between the therapist and the parent and allow other parents to take on a therapeutic role with each other, thus facilitating a positive therapist-parent relationship. Since treatment length is unlimited and because of the shared learning experiences of a group format there is a strong likelihood for preventing further mental illness. The length of treatment may also greatly facilitate correcting the source of the parent-child conflict. The group play therapy experience may facilitate the working through of other problematic issues by viewing other mother-child pairs dealing with a variety of concerns.

The general therapeutic characteristics consist of Rogerian therapy within a group format for an unspecified number of sessions. Play therapy is the primary medium for the mother-child pairs along with parent-therapist discussions. The therapist role is didactic in nature.

Ginsberg (1976) seems to make an unspoken assumption as to the population characteristics and contraindications for treatment. He presumes group filial therapy is effective with the same population groups as individual filial therapy a la Guerney (1964). This would entail treating male and female children from 2 to 10 years old who are the low and middle class socioeconomic background and are diagnosed with the following symptoms: underachievers, educationally disadvantaged, hyperactive, physical handicapped, mildly retarded, blind disabled, enuretic, somatic symptoms, poor eating, nightmares, excessive masturbation, nailbiting, tic-like throat clearing, socially isolated, easily offended, fearful of physical aggression, and flight from peer play. Contraindications for group filial therapy would include those who are autistic, schizophrenic and out of touch with reality, in crisis, and experiencing situational or routine developmental problems.

There is only one study to date that lends research support to this approach to filial therapy. This report is in the original publication outlining Guerney's model. The clients of this study exhibited solitary play, withdrawn behavior, acting-out through fighting with other children and excessive dependence upon adults. After treatment, four of the six children changed

perceptibly as exhibited by cooperative play, increased interaction with peers, and decreased dependence upon adults. Most of the children had single parents from a low socioeconomic status.

To conclude, there is a lack of strong empirical research to support Ginsberg's (1976) claims. However, since group filial therapy is based upon individual filial therapy, which has greater empirical support, there is a positive halo effect for Ginsberg's model. Group filial therapy may be equal to or greater than individual filial therapy in its therapeutic effects. Further research is required to assure the validity and reliability of the treatment outcome. There are similar strengths and weaknesses to the designs using Rogerian and family systems theory.

The four approaches using an integration of Rogerian and family therapy each have specific strengths and weaknesses along these evaluative dimensions. Hornsby and Applebaum's (1978) model fulfills each of the major advantages of paraprofessional training because the parents and the child are intimately involved in the therapeutic process and are aware of each other's presence. This approach also affords increased self awareness of the parent and the child due to the constant, non-intrusive feedback provided by the bug-in-the-ear device allowing

direct communication between the therapist and the parent during play. The conjoint parental therapy session following each play session allows further discussion and clarification of personal and relational problems. A positive therapist-parent relationship is facilitated through an intense focus upon individual and intrafamilial dynamics, thus giving extensive support to the parent-child relationship as a primary focus. The length of treatment is open ended and discussion topics create a breadth and a depth to therapy which increases the probability of preventing further mental illness. Likewise, this facilitates correcting the source of the parent-child conflict and working through other problematic issues.

The general therapy characteristics consist of an individual and conjoint approach within a Rogerian and family systems orientation. The length of treatment for parents and children is unspecified and the therapeutic medium involves play and discussion. The context for therapy includes the parents and the child in closely supervised play sessions with subsequent conjoint parental therapy. The therapist role is primarily didactic.

The authors consider the most effective treatment population to be children who experience adjustment reactions, active conflict with parents, borderline psychosis, organic problems and borderline mental retardation.

They consider it least effective with children who have severe internalized conflicts such as severe neurotic disorders, encopresis, significant personality disorders and psychosis. However, they do not operationally define "severe" or "significant," leaving this somewhat nebulous. They do not make any claims in regards to age range, socioeconomic status or sex of the child.

Concerning empirical evidence, supportive research is primarily gleaned from case studies with children 5, 6 and 8 who experience poor peer relationships, stuttering, multiple behavior difficulties, anxiety, physical handicaps and academic difficulties.

In conclusion, this approach makes excellent use of the bug-in-the-ear device and the parental dyad, which appears to enhance the total treatment effect. This model's content appears thorough and effective based upon face validity and the case study material. However, as in previous models, the case studies provide limited information as to the model's therapeutic effectiveness. Empirical support is lacking and clearer diagnostic descriptions are necessary as contraindicators to treatment.

Safer's (1965) model of conjoint play therapy possesses several strengths, while having some important weaknesses. This occurs since the child and the parent are intimately involved together in therapy. The

parent's involvement is a potent proof of care for the child. The parent and child increase in self awareness since there is ample opportunity for the therapist input and mutual discussion of problems. As a result of an active emphasis upon the parent-child relationship, there is a facilitation of positive therapist-parent relationship. An open agenda to problems facilitates the working through of other problematic issues. Though involvement by both parents is not a requirement, Safer highly recommends that each are involved in the treatment. The participation of both parents would enhance overall treatment. However, if only one parent participates in treatment, there may be a lower probability for preventing mental illness and for correcting the source of the parent-child conflict. The treated parent-child relationship may become skewed as compared to the untreated parent-child relationship. This imbalance creates tension and conflict, resulting in an exacerbation of pathological relating. Such change without professional assistance may actually create further mental illness and a new and more complex conflict between the father, the mother, and the child.

In regards to general therapeutic characteristics, Safer employs an integrated Rogerian-family system approach with conjoint parent-child pairs or triads if both parents participate. Treatment length is unspecified

and therefore may be long term if necessary. The medium for therapy is play. The therapeutic context allows both the parent and the child to be recipients of therapy either at the same time or separately, if the therapist elects to focus on one individual while the other observes. The therapist's role moves from one of equality with the parent to semi-direct involvement to more didactic involvement depending upon the needs of the play session. This allows great versatility in treating the parent-child relationship. Safer claims this approach is useful for children between the ages of 4 and 7.

Concerning population characteristics and contraindicators, he does not address the sex, the diagnosis, the socioeconomic status of the clients or the contraindicators of treatment.

The only research evidence is a case study of a 4½-year-old boy who suffered from temper tantrums, apathy toward peers, excessive imagination, fantasy friends, infantile manners, neologisms, lack of using the first person or the words "Daddy" or "Father" in speech, fearful of going in a car with his parents, requiring his mother to dress him, refusal to urinate unless his mother held his penis and requesting permission for every independent move. After 10 sessions and seven months of treatment, there was a remission of all symptoms. The study is

impressive and may give hints as to potentially treatable diagnosis. However, stronger empirical evidence is necessary.

In conclusion, the conjoint therapy model appears to have excellent potential because of the intimate interaction between the child, the parent and the therapist as manifested in fulfilling certain paraprofessional advantages. Yet, the model lacks the needed empirical support to assure its effectiveness.

Resnick (1976) appears to achieve all of the advantages of paraprofessional training. Since both parents are required to participate in therapy this is an important proof of care for the child. There is an opportunity for increased self awareness of the parent and child because the block playing concretizes an interaction around a specific content and thus minimizes extraneous or unessential information. A positive therapist-parent relationship is facilitated since the therapist's role is to ally equally with the parent and the child. Since this model focuses upon the pathological relationship as manifested in communication there is an opportunity to prevent mental illness and to correct the source of the parent-child conflict eventually. However, other problematic issues may be only addressed in an

indirect manner by focusing upon general feelings and improved communication skills.

The general therapeutic characteristics entail a Rogerian-family system model with conjoint sessions (parent-child) for an unspecified length of treatment. The primary medium is the use of toy blocks. The therapeutic context involves the parent and the child in the same session. The therapist's role involves a semidirective approach by offering facilitative comments and didactic instruction.

Resnick does not specify the treatment population characteristics nor contraindications for treatment. Supporting research consists of case studies with children 12 and 13 years of age who experience difficulty in relating to their parents. He cites that the children and the parents improved their communication patterns and developed greater intimacy as a result of treatment.

In conclusion, the model appears to have broad application with any age group where understanding pathological communication may offer the most effective means for resolving the presenting complaint. However, it is unclear when this may be the treatment of choice. Empirical data is required to ascertain the extent of the treatment effects and the most appropriate treatment population.

Gordon's (1970) Parent Effectiveness Training (P.E.T.) model is ironically one of the most developed models while the most potentially harmful. The possible negative effects on the parent-child relationship range from not impacting the relationship to exacerbating existing pathological relationships. Since the child is not actively involved in the treatment and may be unaware of the parents' involvement this would not be a potent proof of parents' care. There is decreased likelihood for the child to acquire self awareness since the program does not provide adequate supervision to facilitate self-exploration or direct child development. Teaching communication skills which have a broad focus may facilitate working through other problematic issues. However, unless there is adequate self-understanding and vulnerability the problems addressed may likely be superficial or may entrench existing pathology. A review by Doherty and Ryder (1980) presents several major criticisms of P.E.T. such as the paradoxical effect that building powerful communication techniques may enhance the parent's ability to control their children's behavior and increase covert manipulation in the families. According to their review the P.E.T. approach is characterized by harsh unwarranted judgement against parents with the underlying message that parents

have been doing everything wrong. They go on to state that P.E.T. does not adequately identify and build upon the strengths of the parents. A final criticism is that the program may encourage unnecessary guilt for failure to use the P.E.T. approach faithfully, which can create family division since it is common for only one parent to take the course. Extrapolating from Doherty and Ryder's review, the therapist-parent relationship may be more negative than positive. In addition there may be a low probability for preventing mental illness and in fact, the program may even create further pathology because the parents learn skills without adequate self-understanding. Similarly, the parents and instructor may inadvertently ignore the source of the parent-child conflict.

A combination of Rogerian and family systems theory is presented in a group format for 8 sessions with only the parent(s) attending. The therapist's approach is primarily didactic, though he may also use role playing as an additional component to the general therapeutic characteristics.

Concerning the population characteristics, Gordon does not indicate the age, the socioeconomic status, the diagnosis and the sex of the appropriate treatment group. He does not present contraindications for treatment.

There have been several empirical studies investigating P.E.T.'s effectiveness. Goldstien (1980) performed a study to examine the effect of P.E.T., Assertiveness Training (AT) and a Comparison (C) treatment on self-assessed parental attitudes and behavior of mothers. The Parent Attitude Survey Scales (PASS) measured overall attitudes toward parenting, attitudes of confidence, acceptance, understanding and trust, and the Parent Preschool Child Instrument (PPCI) measured behavioral styles of parenting defined as high control, low control, reward and teaching. A total of 48 women participated, with the P.E.T. group attending a 24 hour, eight week P.E.T. course; the AT group attending a 20 hour, ten week AT course; and the C group attending a 20 hour, ten week course in bridge or film evaluation. The results indicated that the P.E.T. group have significantly more negative attitudes on the PASS scales of attitudes toward parenting and attitudes of understanding in comparison to the other two groups. The results from the PPCI indicate the C group has significantly less controlling behavior in comparison to the other groups following treatment. In conclusion, this research did not support the concept that the P.E.T. program significantly improves parental attitudes and behaviors. A study of Fulmer (1980) examined the impact of P.E.T. upon elementary school age

children in the areas of self-perceived locus of control and behavior. After parents completed the P.E.T. course, the treatment and control group received the following tests: the Intellectual Achievement Responsibility Questionnaire administered to the children to measure self perceived locus of control, the Devereux Elementary School Behavior Rating Scale to assess teacher's rating of children's behavior, and the Devereux Child Behavior Rating Scale to assess parent's rating of their children's behavior. The results indicate the P.E.T. program for parents will change children's self-perception and their behavior in the home. The children show more self-perceived internality of control. Also, the children display more self-reliance and assertiveness in their home according to parents. However, findings also indicate the children of P.E.T. trained parents do not demonstrate self-reliant, self-responsible and assertive behavior when observed by teachers. Chant and Nelson (1982) performed a study to determine the effects of a mother's use of I-message and active listening on her 7-year-old daughter's behavior in the house. The child presented symptoms of crying, of arguing, of complaining and of being unable to express her feelings overtly. The experimenter's observations indicated that the mother learned to use I-messages and active listening effectively following training. Similar

observations found that the daughter increased her expression of feeling subsequent to the mother employing the newly learned skills. Though their study lacks empirical support, the findings are encouraging. Larson (1972) published an outcome study with inconclusive results. This study shows positive effects of P.E.T. on parents. However, the researchers failed to use tests of statistical significance in reporting pre-post changes in parent scores. Rinn and Markle (1977) reviewed several master theses and doctoral dissertations which have empirically researched P.E.T. They concluded the present research does not validate claims of P.E.T. as an effective parent training procedure. The research for P.E.T. indicates the program may lead to undesirable parental functioning (Goldstien, 1980) or to improved child functioning (Fulmer, 1980; and Chant & Nelson, 1982) or to no change at all (Larson, 1972; and Rinn & Markle, 1971). More research is necessary to clearly understand the advantages and limitations to the P.E.T. program.

In conclusion, the skills taught to parents appear beneficial and may be helpful, according to at least one study. However, P.E.T. presents a simplistic resolution for ameliorating parent-child problems, assumes it has all the answers to interpersonal satisfaction and has a

naive view of family dynamics and pathology. The intimate and complex interpersonal relationship between parent and child require more than just unsupervised communication techniques to achieve fulfillment. The family dynamics need to be viewed from numerous family systems concepts to satisfactorily address the complicated relationships. Even if Gordon's model for parent training is effective, the mix of empirical evaluations suggest there are serious flaws which may often mitigate against the intended results. This model may be effective with higher functioning adults who have the capacity to independently explore and understand themselves and their children.

Summary and Conclusion

The current models focusing on the parent-child relationship are primarily Rogerian, or Rogerian with procedural variations or Rogerian incorporating family systems theory. Each program focuses upon training the parent to relate in a healthier manner with the child. All of the models explicitly or implicitly support employing their method with male and female children aged 2 to 12 years old with a variety of diagnoses. Most, if not all the therapeutic models have non-existent or inadequate research studies. Some of the models have provided case studies which offer hope that these

approaches are effective. However, this is yet to be proven scientifically. Only Guerney's model has relatively adequate research to support the concepts and the techniques. Though there remains a lack of sufficient empirical data, all the models may be selectively employed depending upon the client's needs and the professional's situation.

Some approaches are more suited to one set of conditions than another. If parent training needs to take place in a group format, then Ginsberg's, Kraft's, Gordon's and Ginott's models would be appropriate. Of these four, Ginsberg would be most effective since it is closely modeled after Ginott's well researched approach. Following this, Ginott would be very effective because of the more experiential and therapeutic setting for the parent and the child. Kraft's model is the next approach to be most effective, and depending on the type of group the parent(s) desires, it may be better received than Ginsberg's or Ginott's if the parents want a more didactic approach. Gordon's model is least recommended, because of the uncertainty of the results as evidenced by several research efforts. Other approaches such as Nickerson's and Resnick's are primarily intended for parent-child pairs but may accommodate to a group format because of the ease with which people may engage in

block playing and art with little supervision. Also, Nickerson's instructions are easily applied to a large audience. If treatment necessitates the parent-child pair be treated exclusively in a pair format, then Hornsby's and Applebaum's or Safer's model would be most appropriate. This is due to the amount of therapeutic expertise and individualized interventions that are necessary in these modalities, and that make these approaches especially attractive to people who require more professional assistance to work through complicated interpersonal dynamics. In those cases where the parent wants to receive some training with minimal involvement then Ginott's approach would be most suitable. The 15 week non-directive orientation allows someone to determine their own amount of involvement with little threat of being coerced beyond where they feel ready. If there is a possibility that other family members may desire or need to be involved in treatment along with the primary child and parents, then the best approach would be those including family systems in their theoretical orientation. Of those four models, Hornsby's and Applebaum's, and Safer's approach would be most flexible in allowing the inclusion of other family members. In contrast, Resnick's model is primarily dyadic and therefore less flexible for the inclusion of other family members. Gordon's model would

also be less effective because he inadequately addresses the complexity of family dynamics.

The models satisfy the paraprofessional training advantages to various degrees. Guerney, Hornsby and Applebaum, and Ginsberg seem most effective; Safer, Resnick and Ginott are moderately effective; and Gordon, Nickerson and Kraft are least effective in fulfilling these dimensions.

Some models are more suited to short term treatment than to long term treatment. If short-term therapy is required the most efficient approaches include Gordon's model with eight sessions, Kraft's model with 10 sessions, and Ginott's with 15 sessions. Ginott's program is recommended if the parent is best served with a short-term model emphasizing self-exploration while deemphasizing skill acquisition through didactic instruction. relatively high functioning parents are likely candidates for this training. Between Kraft's and Gordon's approach, the former is recommended for parents requiring an emphasis in skill development. Gordon's model may be beneficial for some parents who have minimal pathology. However, to counteract the potentially negative effects of the program, the parents would likely need adequate intellectual sophistication and the capacity to synthesize the P.E.T. principles within a broader view

of interpersonal relationships. Because few parents seeking treatment for a troubled parent-child relationship may actually possess these attributes, Kraft's model is recommended over Gordon's program. If long term treatment is indicated or desired, then Guerney's, Hornsby and Applebaum's, Nickerson's, Safer's, Resnick's and Ginsberg's would be more adequate.

Depending upon the level of pathology some models may afford greater opportunity for success because of the personalized supervision of a trained therapist. If there is a high level of pathology, then more supervision would be indicated. The Guerney, Hornsby and Applebaum, Resnick, Ginsberg and Safer models provide this needed supervision. For a low level of pathology, Gordon's, Kraft's and Ginott's approaches give the least amount of supervision to the client and rely more upon the parents' judgement and self-awareness for effective application.

Lastly, the interfacing of diagnosis with the most ameliorative treatment has been unproven. Only Hornsby and Applebaum, Ginott and Guerney offer diagnostic guidelines for including a child in treatment, and these are based primarily on conceptual rather than empirical analysis. For example, Guerney originally hypothesized children with multiple brain disorder would be ineligible

for filial therapy treatment. However, as a result of a child accidentally being included in such treatment it was found that this problem is also treatable with filial therapy. Because the criteria for inclusion in treatment remains unclear there is little reason to exclude a child from treatment; even the presumed untreatable may terminate successfully.

To conclude, all the models are promising and may be quite effective if employed in the specific circumstances with the most appropriate population. For the most part this decision is based upon educated analysis of case studies rather than valid and reliable empirical evidence. The current state of research in this area necessitates improved assessment instruments and further investigation into the successful/unsuccessful treatment components and the appropriate treatment population characteristics. However, based upon conceptual considerations, the various models may be employed with relative confidence if the clinician matches the circumstances for treatment and the client's characteristics with the treatment model's characteristics.

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